Amt. Recd. $____
Check #_____

2026 APPLICATION FOR MEMBERSHIP
in the
KANSAS ORGANIZATION OF SKILLED CARE PROFESSIONALS

☐ New Membership ☐ Renewal

I hereby apply for membership in KOSCP and certify that I meet the membership requirements.

Membership Eligibility Requirements

Active Full membership, with voting privileges, shall be available to persons who are currently employed by a KHA member institution, either full or part time, and involved in the delivery of skilled care services. Only full members shall be eligible to serve as Officers and Directors of the Kansas Organization of Skilled Care Professionals.

Please type or print clearly.

NAME _____
(Last) (First) (Middle Initial)

TITLE OF POSITION _____

HOSPITAL _____
(Name)

_____
(Street) (City) (Zip Code)

PHONE # _____ E-MAIL ADDRESS _____

(Area Code) (Number)

TYPE OF FACILITY: (Please circle the ones that apply.)

☐ LTC ☐ PPS, CAH, REH ☐ Freestanding Skilled Unit ☐ Distinct Hospital-Based Skilled Unit

OTHER DEPARTMENTS WITHIN THE HOSPITAL FOR WHICH I AM RESPONSIBLE ARE:

_____

HOME ADDRESS_____
(Street) (City) (Zip Code)

$50.00 membership fee enclosed. Please make checks payable to the Kansas Organization of Skilled Care Professionals and return application and check to: Kansas Organization of Skilled Care Professionals, 215 SE 8th Ave., Topeka, KS 66603.

Following the initial application, membership fees will be due by February 28, 2026.

_____ _____
Signature of Applicant Nursing License Number